Etanercept (Enbrel®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	RETAIL
IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here ☐	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: **Etanercept (Enbrel®)**

Step 1

Please complete patient and physician information (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Secure Fax #: _____

Step 2

Please complete the clinical assessment:

1. Is this a continuation of therapy with etanercept?	☐ Yes Coverage approved, limited to a 4-week supply in retail and an 8-week supply in mail order.	☐ No Please proceed to Question 2
2. Will the patient be receiving adalimumab (Humira®), anakinra (Kineret®), or infliximab (Remicade®) in combination with etanercept?	☐ Yes Coverage not approved	☐ No Please proceed to Question 3
3. Is the patient diagnosed with juvenile rheumatoid arthritis?	☐ Yes Please proceed to Question 4	☐ No Please proceed to Question 5
4. Has the patient had an inadequate response to at least one disease-modifying anti-rheumatic drug (DMARD)?	☐ Yes Coverage approved, limited to a 4-week supply in retail and an 8-week supply in mail order.	☐ No Coverage not approved
5. Is etanercept being prescribed for the treatment of moderately to severely active rheumatoid arthritis, the treatment of active psoriatic arthritis, or the treatment of ankylosing spondylitis?	☐ Yes Coverage approved, limited to a 4-week supply in retail and an 8-week supply in mail order.	☐ No Please proceed to Question 6
6. Is etanercept being prescribed for the treatment of chronic moderate to severe plaque psoriasis?	☐ Yes Please proceed to Question 7	☐ No Coverage not approved
7. Is the patient a candidate for phototherapy or systemic therapy?	☐ Yes Please proceed to Question 8	☐ No Coverage approved, limited to a 4-week supply in retail and an 8-week supply in mail order.
8. Has the patient tried and failed traditional therapy for psoriasis, such as phototherapy (e.g., UVB, PUVA) or systemic therapy (e.g., methotrexate, acitretin, cyclosporine)?	☐ Yes Coverage approved, limited to a 4-week supply in retail and an 8-week supply in mail order.	☐ No Coverage not approved

Step 3

I certify the above is correct and accurate to the best of my knowledge.

Please sign and date:

_____ _____

Prescriber Signature Date

Latest revision: Jan 2006